		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037507

Facility Name: Sherman West Court

Address: 1950 Larkin Avenue (Number) Elgin (City) 60123-5843 (Zip Code)

County: Kane

Telephone Number: (847) 742-7070 **Fax #** (847) 742-7248

IDPA ID Number: 363725580001

Date of Initial License for Current Owners: 02/18/91

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 384-6000
Please send copies of desk review and audit adjustments to address on this page.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 05/01/03 to 04/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 384-6000 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/03 Ending: 04/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	112	Skilled (SNF)	112	40,992	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	8	Sheltered Care (SC)	8	2,928	5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,385	16,547	10,560	30,492	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		3,389		3,389	12
13	DD 16 OR LESS					13
14	TOTALS	3,385	19,936	10,560	33,881	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 77.14%

D. How many bed-hold days during this year were paid by Public Aid? None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/18/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/18/91 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 34 and days of care provided 10,560

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 04/30/04 Fiscal Year: 04/30/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 **Report Period Beginning:** 05/01/03 **Ending:** 04/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	256,458	11,738	3,419	271,615		271,615		271,615			1
2	Food Purchase		151,257		151,257		151,257	(4,814)	146,443			2
3	Housekeeping	87,421		16,505	103,926		103,926		103,926			3
4	Laundry	35,844	9,816		45,660		45,660		45,660			4
5	Heat and Other Utilities			125,598	125,598		125,598		125,598			5
6	Maintenance	101,813	2,551	51,047	155,411		155,411		155,411			6
7	Other (specify):*											7
8	**TOTAL General Services**	481,536	175,362	196,569	853,467		853,467	(4,814)	848,653			8
	B. Health Care and Programs											
9	Medical Director			42,300	42,300		42,300		42,300			9
10	Nursing and Medical Records	2,214,244	76,319	2,865	2,293,428		2,293,428		2,293,428			10
10a	Therapy	298,463	651	10,307	309,421		309,421		309,421			10a
11	Activities	62,997	4,185	2,296	69,478		69,478	1,714	71,192			11
12	Social Services	40,869			40,869		40,869		40,869			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,616,573	81,155	57,768	2,755,496		2,755,496	1,714	2,757,210			16
	C. General Administration											
17	Administrative	82,070		229,485	311,555		311,555	(229,485)	82,070			17
18	Directors Fees											18
19	Professional Services			59,589	59,589		59,589	(3,816)	55,773			19
20	Dues, Fees, Subscriptions & Promotions			33,435	33,435		33,435		33,435			20
21	Clerical & General Office Expenses	314,359	7,481	44,452	366,292		366,292	201,271	567,563			21
22	Employee Benefits & Payroll Taxes			712,414	712,414		712,414		712,414			22
23	Inservice Training & Education											23
24	Travel and Seminar			11,254	11,254		11,254		11,254			24
25	Other Admin. Staff Transportation			138	138		138		138			25
26	Insurance-Prop.Liab.Malpractice			236,164	236,164		236,164		236,164			26
27	Other (specify):*											27
28	**TOTAL General Administration**	396,429	7,481	1,326,931	1,730,841		1,730,841	(32,030)	1,698,811			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,494,538	263,998	1,581,268	5,339,804		5,339,804	(35,130)	5,304,674			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

****See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Sherman West Court #0037507 Report Period Beginning: 05/01/03 Ending: 04/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7**	8	9	10	
	D. Ownership											
30	Depreciation			239,020	239,020		239,020	16,420	255,440			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			229,098	229,098		229,098	(24,567)	204,531			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			10,088	10,088		10,088		10,088			35
36	Other (specify):*											36
37	**TOTAL Ownership**			478,206	478,206		478,206	(8,147)	470,059			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			287	287		287		287			38
39	Ancillary Service Centers		676,618		676,618		676,618		676,618			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,488	61,488		61,488		61,488			42
43	Other (specify):* Nonallowable Costs			81,771	81,771		81,771	(81,771)				43
44	**TOTAL Special Cost Centers**		676,618	143,546	820,164		820,164	(81,771)	738,393			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,494,538	940,616	2,203,020	6,638,174		6,638,174	(125,048)	6,513,126			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/03 Ending: 04/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,734)	2		4
5	Telephone, TV & Radio in Resident Rooms	(5,500)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(627)	30		9
10	Interest and Other Investment Income	(24,567)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,188)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(33,884)	43		24
25	Fund Raising, Advertising and Promotional	(13,980)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule 5A	(39,286)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (122,766)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(2,282)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (2,282)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (125,048)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Sherman West Court
IDPH Facility ID # 0037507
4/30/2004

Schedule 5A

Schedule VI.
Line 29, Other

Nonallowable Expenses	Amount	Reference
Printing and forms	(1,927)	43
Lab expense	(30,002)	43
Residents clothing	(790)	43
Out of period legal fees	(3,816)	19
Miscellaneous income offset	(3,385)	4
Activity income offset	1,714	11
Vending income offset	(1,080)	2
Total	(39,286)	

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Sherman West Court

ID# **0037507**

Report Period Beginning: **05/01/03**

Ending: **04/30/04**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sherman West Court # 0037507 **Report Period Beginning:** 05/01/03 **Ending:** 04/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,734)	0	0	0	0	0	0	0	0	0	0	(3,734)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,734)	0	0	0	0	0	0	0	0	0	0	(3,734)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(229,485)	0	0	0	0	0	0	0	0	0	(229,485)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(5,500)	210,156	0	0	0	0	0	0	0	0	0	204,656	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(5,500)	(19,329)	0	0	0	0	0	0	0	0	0	(24,829)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(9,234)	(19,329)	0	0	0	0	0	0	0	0	0	(28,563)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Sherman West Court # 0037507 **Report Period Beginning:** 05/01/03 **Ending:** 04/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(627)	17,047	0	0	0	0	0	0	0	0	0	16,420	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(24,567)	0	0	0	0	0	0	0	0	0	0	(24,567)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(25,194)	17,047	0	0	0	0	0	0	0	0	0	(8,147)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(49,052)	0	0	0	0	0	0	0	0	0	0	(49,052)	43
44	**TOTAL Special Cost Centers**	(49,052)	0	0	0	0	0	0	0	0	0	0	(49,052)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(83,480)	(2,282)	0	0	0	0	0	0	0	0	0	(85,762)	45

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/03 Ending: 04/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Sherman Health Systems	100%			Sherman Hospital	Elgin	Hospital
				Sherman Home		Home Health
				Care Partners	Elgin	Agency
				Sherman Health		
				Systems	Elgin	Management Co.
See Schedule 6A for Board of Directors						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 229,485	Sherman Health Systems	100.00%	$	$ (229,485)	1
2	V	21	Administrative Expenses		Sherman Health Systems	100.00%	210,156	210,156	2
3	V	30	Depreciation Expense		Sherman Health Systems	100.00%	17,047	17,047	3
4	V	10	Nursing Cost	13,417	Sherman Hospital		13,417		4
5	V	22	Fringe Benefits	285,448	Sherman Hospital		285,448		5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 528,350			$ 526,068	$ * (2,282)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Sherman West Court
Facility #0037507
04/30/2004

Medicaid Cost Report
Schedule 6A

Page 6: VII - Schedule A - Non-Profit required attachment: List of Board of Directors

Board Member	Directly Provided Services	Type of Service	Entity owned by Board Member doing Business with nursing home	Type of Business Conducted
Reverend Dr. Robert D. Linstrom	No	N/A	N/A	N/A
Richard S.Scheflow	No	N/A	N/A	N/A
Earl W. Lamp	No	N/A	N/A	N/A
Al Pagorski	No	N/A	N/A	N/A
Toni Geister	No	N/A	N/A	N/A
Richard Floyd	No	N/A	N/A	N/A
Kyung W. Koo, M.D.	Yes	Medicare Medical Director	N/A	N/A
Elaine Hastings	No	N/A	N/A	N/A
D. Ray Wilson	No	N/A	N/A	N/A

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/03 Ending: 04/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3					N/A						3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/03 Ending: 04/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sherman Health Systems
Street Address: 1019 East Chicago Street
City / State / Zip Code: Elgin, IL 60120-6822
Phone Number: (847) 608-6114
Fax Number: (847) 608-6117

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Administrative Expenses	Accumulated Costs	213,418,550	3	$ 6,791,213	$	6,604,294	$ 210,156	1
2	30	Depreciation Expense	Accumulated Costs	213,418,550	3	550,873		6,604,294	17,047	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 7,342,086	$		$ 227,203	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/03 Ending: 04/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Illinois Health Facilities		x	Refinance construction bond	$24,326.00	10/15/97	$ 4,736,121	$ 4,211,788	8/2027	Various	$ 229,098	1
2	Authority											2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$24,326.00		$ 4,736,121	$ 4,211,788			$ 229,098	9
	B. Non-Facility Related*											
10								Interest Income Offset			(24,567)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (24,567)	14
15	TOTALS (line 9+line14)						$ 4,736,121	$ 4,211,788			$ 204,531	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/03 Ending: 04/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

No real estate taxes to be paid in 2003 or 2004 due to real estate tax exempt status being granted.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sherman West Court COUNTY Kane

FACILITY IDPH LICENSE NUMBER 0037507

CONTACT PERSON REGARDING THIS REPORT Ms. Anne Huang

TELEPHONE (847) 742-7070 FAX #: (847) 742-7248

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/03 Ending: 04/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 40,260 B. General Construction Type: Exterior Brick Frame Wood/Masonry Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	115,500	1991	$ 504,179	1
2					2
3	TOTALS	115,500		$ 504,179	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/03 Ending: 04/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120		1991	1991	$ 2,486,860	$ 62,171	40	$ 62,171	$	$ 821,181	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements			1991	99,031		5			99,031	9
10	Building Improvements			1991	219,089		10			219,089	10
11	Building Improvements			1991	205,843	15,026	15	13,723	(1,303)	181,257	11
12	Building Improvements			1991	826,676	41,334	20	41,334		545,952	12
13	Building Improvements			1991	91,155	3,646	25	3,646		48,159	13
14	Building Improvements			1991	21,960		10			21,960	14
15	Building Improvements			1991	3,398	227	15	227		2,833	15
16	Building Improvements			1992	22,980		10			22,980	16
17	Building Improvements			1992	2,000	183	15	133	(50)	1,532	17
18	Building Improvements			1993	962		5			962	18
19	Building Improvements			1993	13,219	661	10	661		13,219	19
20	Building Improvements			1993	3,750	250	15	250		2,625	20
21	Building Improvements			1993	14,525		20	726	726	7,624	21
22	Building Improvements			1994	6,951	348	20	348		3,303	22
23	Carpet Tiles			1995	1,500	150	10	150		1,275	23
24	Sliding Doors			1996	3,345	334	10	334		2,842	24
25	Resurface Parking Lot			1996	4,800		5			4,800	25
26	Carpeting			1997	3,930		5			3,930	26
27	Carpet/tile Base			1997	12,580		5			12,580	27
28	Kickplates			1997	4,165		5			4,165	28
29	Carpet Living Room			1998	4,340	433	10	433		2,383	29
30	Cement Board & Ceramic Tile			1999	4,475	448	10	448		2,464	30
31	Wallpaper			1999	1,819	184	5	184		1,819	31
32	Landscaping			1999	893	88	5	88		893	32
33	Construction contract for new entrance & nursing station			1999	938,914	23,473	40	23,473		114,924	33
34	Kitchen Wall Boards			2000	1,365	273	5	273		1,228	34
35	Parking Lot Improvements			2000	52,250	1,742	30	1,742		6,968	35
36	Purchasing Department Ceiling Light Fixtures			2000	1,967	197	10	197		788	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/03 Ending: 04/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Carpeting	2002	$ 19,785	$ 3,957	5	$ 3,957	$	$ 8,080	37
38	Wallpaper	2002	19,893	3,979	5	3,979		8,124	38
39	Roofing	2001	1,400	140	10	140		350	39
40	Door	2001	1,125	75	15	75		188	40
41	Carpeting	2003	5,732	1,146	5	1,146		1,719	41
42	Carpeting	2003	1,855	371	5	371		557	42
43	Wiring for therapy rooms	2003	4,431	443	10	443		665	43
44	HVAC upgrade and testing	2003	52,902	3,527	15	3,527		5,291	44
45	Fire sprinklers	2003	12,149	607	20	607		911	45
46	HVAC upgrade and testing	2003	51,875	5,188	10	5,188		10,376	46
47	Light fixtures and wiring for cafeteria	2004	3,967	198	10	198		198	47
48	Wallpaper	2004	6,868	687	5	687		687	48
49	Vent pipe	2004	1,068	107	5	107		107	49
50	Vinyl base	2004	900	90	5	90		90	50
51	HVAC upgrade and testing	2004	8,909	297	15	297		297	51
52	Door holder	2004	1,056	35	15	35		35	52
53	Circuit breaker	2004	2,250	75	15	75		75	53
54	Door plate	2004	2,053	68	15	68		68	54
55	Sewer line and trap	2004	2,950	98	15	98		98	55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 5,255,910	$ 172,256		$ 171,629	$ (627)	$ 2,190,682	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/03 Ending: 04/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 621,025	$ 65,665	$ 65,665	$	5-20 years	$ 343,783	71
72	Current Year Purchases	15,992	1,099	1,099		5-15 years	1,099	72
73	Fully Depreciated Assets	569,403				5-10 years	569,403	73
74	Allocated from Sherman Health Systems			17,047	17,047			74
75	TOTALS	$ 1,206,420	$ 66,764	$ 83,811	$ 17,047		$ 914,285	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,966,509	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 239,020	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 255,440	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 16,420	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,104,967	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/03 Ending: 04/30/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 10,088 Description: Copy Machines: $10,088
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/03 Ending: 04/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L 10A, C 1	3569 hrs	$ 78,518		$	$	3,569	$ 78,518	1
2	Licensed Speech and Language Development Therapist	L10A, C 1	1130 hrs	19,073				1,130	19,073	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C 1 & 2	7174 hrs	200,872			651	7,174	201,523	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C 2	# of prescrpts				641,101		641,101	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Specialized Beds Other (specify): Oxygen	L39, C 2 L39, C 2					6,137 29,380		6,137 29,380	13
14	TOTAL			$ 298,463		$	$ 677,269	11,873	$ 975,732	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 **Report Period Beginning:** 05/01/03 **Ending:** 04/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 04/30/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,020,782	$ 1,020,782	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 190,667)	1,102,079	1,102,079	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	116,826	116,826	6
7	Other Prepaid Expenses	9,648	9,648	7
8	Accounts Receivable (owners or related parties)	86,437	86,437	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,335,772	$ 2,335,772	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	504,179	504,179	13
14	Buildings, at Historical Cost	5,243,191	5,255,910	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,206,244	1,206,420	16
17	Accumulated Depreciation (book methods)	(3,094,209)	(3,104,967)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Bond Issue Cost	63,939	63,939	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,923,344	$ 3,925,481	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,259,116	$ 6,261,253	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 89,001	$ 89,001	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	89,100	89,100	29
30	Accrued Salaries Payable	282,111	282,111	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	55,403	55,403	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Parties	461,394	461,394	36
37	Deferred Income, Accrued Expenses	299,901	299,901	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,276,910	$ 1,276,910	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	4,122,688	4,122,688	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,122,688	$ 4,122,688	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,399,598	$ 5,399,598	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 859,518	$ 861,655	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,259,116	$ 6,261,253	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/03 Ending: 04/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,642,189)	1
2	Restatements (describe):		2
3	**Prior period audit adjustments**	2,327,743	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 685,554	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	173,964	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 173,964	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 859,518	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/03 Ending: 04/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,249,176	1
2	Discounts and Allowances for all Levels	(1,696,374)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,552,802	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,021,894	6
7	Oxygen	97,446	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,119,340	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	3,768	13
14	Non-Patient Meals	3,734	14
15	Telephone, Television and Radio	5,500	15
16	Rental of Facility Space		16
17	Sale of Drugs	915,208	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	22,300	19
20	Radiology and X-Ray		20
21	Other Medical Services	162,168	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,112,678	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	24,567	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 24,567	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	2,751	27
28	Miscellaneous, Vending, & Activities Income		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,751	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,812,138	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	853,467	31
32	Health Care	2,755,496	32
33	General Administration	1,730,841	33
	B. Capital Expense		
34	Ownership	478,206	34
	C. Ancillary Expense		
35	Special Cost Centers	758,676	35
36	Provider Participation Fee	61,488	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,638,174	40
41	**Income before Income Taxes (line 30 minus line 40)****	173,964	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 173,964	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/03 Ending: 04/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,778	4,175	$ 122,627	$ 29.37	1
2	Assistant Director of Nursing					2
3	Registered Nurses	36,481	39,469	1,047,567	26.54	3
4	Licensed Practical Nurses	2,780	2,953	60,897	20.62	4
5	Nurse Aides & Orderlies	60,181	65,499	882,002	13.47	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	8,162	8,544	238,272	27.89	7
8	Rehab/Therapy Aides	3,610	3,969	60,191	15.17	8
9	Activity Director	1,704	1,848	32,647	17.67	9
10	Activity Assistants	3,011	3,316	30,350	9.15	10
11	Social Service Workers	1,907	2,091	40,869	19.55	11
12	Dietician	1,186	1,214	25,494	21.00	12
13	Food Service Supervisor	3,996	4,232	88,888	21.00	13
14	Head Cook	4,050	4,399	45,090	10.25	14
15	Cook Helpers/Assistants					15
16	Dishwashers	12,277	13,124	96,986	7.39	16
17	Maintenance Workers	5,265	5,479	101,813	18.58	17
18	Housekeepers	9,921	11,564	87,421	7.56	18
19	Laundry	3,722	4,371	35,844	8.20	19
20	Administrator	1,950	2,091	82,070	39.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,899	2,091	61,633	29.48	23
24	Clerical	15,746	17,267	252,726	14.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,776	1,912	24,099	12.60	31
32	Other Health C: See Sch. 20A	4,388	4,742	77,052	16.25	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	187,790	204,350	$ 3,494,538 *	$ 17.10	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant	Monthly	42,300	L 9, C 3	37
38	Nurse Consultant	20	1,392	L 10, C 3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	48	1,440	L 10, C 3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	16	760	L 11, C 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	84	$ 45,892		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	N/A			51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Sherman West Court
IDPH Facility ID # 0037507
4/30/2004

Schedule 20A

Schedule XVIII
Line 32, Other

Description	Hours Worked	Hours Paid	Salaries/ Wages	Average
MDS Coordinator	1,771	1,906	47,290	24.81
Nursing Secretary	2,617	2,836	29,762	10.49
Total	4,388	4,742	77,052	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/03 Ending: 04/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Anne Huang	Administrator	0%	$ 82,070
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,070

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ 229,485
TOTAL (agree to Schedule V, line 17, col. 3)	$ 229,485
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Scheflow & Rydell	Legal	$ 4,839
Altschuler, Melvoin & Glasser LLP	Accounting	8,332
Ernst & Young, LLP	Accounting	2,113
Ivan's Service	Computer Consulting	4,961
Accu-Med Services Inc.	Computer Consulting	6,940
Comprehensive Therapeutics	Alzheimers Consulting	6,044
Sylvia Klava	IDPH Consulting	2,562
Murer Consultants	Assisted Living Consulting	23,798
See Schedule 21A		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 59,589

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 130,867
Unemployment Compensation Insurance	21,666
FICA Taxes	266,983
Employee Health Insurance	150,964
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Contributions	47,176
Employee Benefits PTO	60,387
Other Employee Insurance	17,593
Other Employee Benefits	16,778
TOTAL (agree to Schedule V, line 22, col.8)	$ 712,414

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,400
Advertising: Employee Recruitment	19,862
Health Care Worker Background Check	
(Indicate # of checks performed)	
Life Services Network	4,532
Miscellaneous Dues & Subscriptions	3,746
Miscellaneous License, Permits	895
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,435

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	11,254
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 11,254

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Sherman West Court
Provider #: 0037507
05/01/03 to 04/30/04 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	59,589
Less: Out of period legal fees	(3,816)
Total (agree to Schedule V, line 19, column 8)	55,773

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 Report Period Beginning: 05/01/03 Ending: 04/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Sherman West Court # 0037507 **Report Period Beginning:** 05/01/03 **Ending:** 04/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $4,532**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **24,163** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **61,488**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,734**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ernst & Young LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Audit currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	256,458	11,738	3,419	271,615	0	271,615	0	271,615
2. Food Purchase	0	151,257	0	151,257	0	151,257	-4,814	146,443
3. Housekeeping	87,421	0	16,505	103,926	0	103,926	0	103,926
4. Laundry	35,844	9,816	0	45,660	0	45,660	0	45,660
5. Heat and Other Utilities	0	0	125,598	125,598	0	125,598	0	125,598
6. Maintenance	101,813	2,551	51,047	155,411	0	155,411	0	155,411
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	481,536	175,362	196,569	853,467	0	853,467	-4,814	848,653
9. Medical Director	0	0	42,300	42,300	0	42,300	0	42,300
10. Nursing & Medical Records	2,214,244	76,319	2,865	2,293,428	0	2,293,428	0	2,293,428
10a. Therapy	298,463	651	10,307	309,421	0	309,421	0	309,421
11. Activities	62,997	4,185	2,296	69,478	0	69,478	1,714	71,192
12. Social Services	40,869	0	0	40,869	0	40,869	0	40,869
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	2,616,573	81,155	57,768	2,755,496	0	2,755,496	1,714	2,757,210
17. Administrative	82,070	0	229,485	311,555	0	311,555	-229,485	82,070
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	59,589	59,589	0	59,589	-3,816	55,773
20. Fees, Subscriptions & Promotion	0	0	33,435	33,435	0	33,435	0	33,435
21. Clerical & General Office	314,359	7,481	44,452	366,292	0	366,292	201,271	567,563
22. Employee Benefits & Payroll	0	0	712,414	712,414	0	712,414	0	712,414
23. Inservice Training & Education	0	0	0	0	0	0	0	0
24. Travel and Seminar	0	0	11,254	11,254	0	11,254	0	11,254
25. Other Admin. Staff Trans	0	0	138	138	0	138	0	138
26. Insurance-Prop.Liab.Malpractice	0	0	236,164	236,164	0	236,164	0	236,164
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	396,429	7,481	1,326,931	1,730,841	0	1,730,841	-32,030	1,698,811
29. Total General Administrative	3,494,538	263,998	1,581,268	5,339,804	0	5,339,804	-35,130	5,304,674
30. Depreciation	0	0	239,020	239,020	0	239,020	16,420	255,440
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	229,098	229,098	0	229,098	-24,567	204,531
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	10,088	10,088	0	10,088	0	10,088
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	478,206	478,206	0	478,206	-8,147	470,059
38. Medically Necessary T	0	0	287	287	0	287	0	287
39. Ancillary Service Cent	0	676,618	0	676,618	0	676,618	0	676,618
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	61,488	61,488	0	61,488	0	61,488
43. Other (specify):*	0	0	81,771	81,771	0	81,771	-81,771	0
44. Total Special Cost Ce	0	676,618	143,546	820,164	0	820,164	-81,771	738,393
45. Grand Total	3,494,538	940,616	2,203,020	6,638,174	0	6,638,174	-125,048	6,513,126

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,020,782	1,020,782
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,102,079	1,102,079
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	116,826	116,826
7. Other Prepaid Expenses	9,648	9,648
8. Accounts Receivable-Owner/Related Party	86,437	86,437
9. Other (specify):	0	0
10. Total current assets	2,335,772	2,335,772
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	504,179	504,179
14. Buildings, at Historical Cost	5,243,191	5,255,910
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	1,206,244	1,206,420
17. Accumulated Depreciation (book methods)	-3,094,209	-3,104,967
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	63,939	63,939
24. Total Long-Term Assets	3,923,344	3,925,481
25. Total Assets	6,259,116	6,261,253
CURRENT LIABILITIES		
26. Accounts Payable	89,001	89,001
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	89,100	89,100
30. Accrued Salaries Payable	282,111	282,111
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	55,403	55,403
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	461,394	461,394
37. Other Current Liabilities (specify):	299,901	299,901
38. Total Current Liabilities	1,276,910	1,276,910
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	4,122,688	4,122,688
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	4,122,688	4,122,688
46.Total Liabilities	5,399,598	5,399,598
47.Total Equity	859,518	861,655
48.Total Liabilities and Equity	6,259,116	6,261,253

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	6,249,176
2. Discounts and Allowances for all Levels	-1,696,374
Subtotal - Inpatient Care	4,552,802
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,021,894
7. Oxygen	97,446
Subtotal - Anciliary Revenue	1,119,340
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	3,768
14. Non-Patient Meals	3,734
15. Telephone, Television, and Radio	5,500
16. Rental of Facility Space	0
17. Sale of Drugs	915,208
18. Sale of Supplies to Non-Patients	0
19. Laboratory	22,300
20. Radiologyand X-Ray	0
21. Other Medical Services	162,168
22. Laundry	0
Subtotal - Other Operating Revenue	1,112,678
24. Contributions	0
25. Interest and Other Investments Income	24,567
Subtotal - Non-Operating Revenue	24,567
27. Other Revenue (specify):	2,751
28. Other Revenue (specify):	0
Subtotal - Other Revenue	2,751
30. Total Revenue	6,812,138
31. General Services	853,467
32. Health Care	2,755,496
33. General Administration	1,730,841
34. Ownership	478,206
35. Special Cost Centers	758,676
35. Provider Participation Fee	61,488
37. Other	0
40. Total Expenses	6,638,174
41. Income Before Income Taxes	173,964
42. Income Taxes	0
43. Net Income or Loss for the Year	173,964